Exhibit 12

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

LESLIE MCDERMOTT,)
Plaintiff,) CIVIL ACTION
vs.) BI, 17-cv-4511 (MAK)
GREAT LAKES DREDGE)
AND DOCK CO.,)
Defendant.)

VIDEOTAPED DEPOSITION OF DARREN A. FRANK, M.D., taken pursuant to the Federal Rules of Civil Procedure, before Mary Secot, Certified Court Reporter-Notary Public in and for the Commonwealth of Pennsylvania, on Wednesday, July 18, 2018, at 1307 Federal Street, Pittsburgh, Pennsylvania 15219, commencing at 4:30 o'clock p.m.

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A P P E A R A N C E S

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I N D E X

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P R O C E E D I N G S

(4:31 o'clock p.m.)

(Frank Deposition Exhibit Nos. 1 through 5 were marked for identification.)

VIDEOGRAPHER: This is the videotape deposition of Dr. Darren Frank taken in the matter of Leslie McDermott versus Great Lakes Dredge and Dock Company filed in the United States District Court, Eastern District of Pennsylvania, Case. No. 17-cv-4511.

This deposition is being held at 1307 Federal Street, Pittsburgh, Pennsylvania 15219 on Wednesday, July 18, 2018. My name is Dax Parise, video specialist. The court reporter is Mary Secot from Douget Court Reporting with offices at 3207 Landfair, Lake Charles, Louisiana 70601.

We are going on the record. The time is approximately 4:31 p.m. Counsel will please state their appearance for the record.

MR. MORGAN: Good afternoon. My name is Reed Morgan. I represent Leslie McDermott.

MR. DeGIULIO: Good afternoon. Frank DeGiulio representing Great Lakes Dredge and Dock Company.

VIDEOGRAPHER: Thank you. The court reporter will now swear in the witness.

DARREN A. FRANK, M.D.,

the witness, having been first duly sworn, was deposed and testified as follows:

EXAMINATION

BY MR. MORGAN:

Q. Good afternoon, Dr. Frank.

A. Good afternoon.

Q. As you know, we're here to take your testimony in the case where Les McDermott has filed a lawsuit against his employer, Great Lakes Dredge and Dock Company.

I would like to start the deposition today by having you tell us about your college, medical school and residency training.

A. I graduated from Duquesne University in 1995. I went on to pursue a Master's degree in Philadelphia, followed by medical school at Drexel University College of Medicine. It was then known as Medical College of Pennsylvania and Hahnemann University. It since changed names.

I graduated with a Doctor of Medicine in 2001. I went on to pursue further training. After the M.D. in orthopedic surgery I did five years of

orthopedic surgery post-graduate training at Allegheny General Hospital in Pittsburgh, Pennsylvania.

I did an additional year of fellowship training in arthroscopy and sports medicine at New York University Hospital for joint diseases in Manhattan.

I've been employed with the Allegheny Health Network since August of 2007 as an orthopedic surgeon specializing in sports medicine and arthroscopic surgery.

Q. All right. Thank you. Can you tell us please in your practice of medicine here did you become board certified after you had done the requisite number of years of practice?

A. I did. I am board certified in orthopedic surgery with subspecialty certification in sports medicine.

Q. And in order to become board certified in orthopedics, what did you have to accomplish?

A. Complete passage of a written examination, as well as an oral examination, and then an additional written examination for subspecialty certification.

Q. And the subspecialty certification is in what?

A. Sports medicine.

Q. Okay. Thank you. Is that the highest degree of certification you can have in those two areas?

A. That is.

Q. Okay. Thank you. Now, tell us a little bit about your practice here at Allegheny Health Network. What type of patients, in what walk of life do you see for what kinds of injuries?

A. I see patients from a broad, a broad based walk of life. I see a demographic from approximately a 12-year-old to 80-year-old patients in terms of age.

I see a variety of athletes. I see people who are injured at work. I see people who are injured doing all sorts of things, really any activity. Primarily for knee and shoulder injuries.

Q. Okay. Tell us with respect to your surgical practice and experience in doing operations on persons that have torn meniscus approximately how many of those patients do you treat a year, do you believe?

A. Operatively?

Q. Operatively, yes.

A. Probably 200 to 250 patients.

Q. All right. So, in essence, that would mean that of those 200 to 250, those people go to surgery and you try to help them through a repair of the meniscus?

A. Repair or resection, yes.

Q. Or resection. I saw in the literature, there's actually, and actually it was in your notes when you discussed the case with your patient, Mr. McDermott, there's two types of health options that you give a patient with a torn meniscus; aren't there?

A. Yes. Well, in terms of surgical treatment?

Q. In terms of surgical, sure.

A. Yes. There are two types of surgeries done for a meniscal tear, either a partial resection or a repair, and the criteria depends upon, you know, chronicity of tear, the location of the tear, how much blood supply there is, and the quality of the tissue.

Q. And when you say repair, what does that involve?

A. Repair would involve actually stitching the tear edges together in an effort to get it to heal.

Q. Okay. What is the other option?

A. Just removing the torn part.

Q. All right. We're going to get into the details a bit here in a moment on what happened with your surgery on Mr. McDermott, but just so we kind of have a pre-story of what this is about, did you do a repair or a resection on him?

A. A partial resection.

Q. Okay. Which means what?

A. Removing the torn part of the meniscus. In Mr. McDermott's case the tear was not amenable to a repair.

Q. Why is that?

A. Due to its location in the central aspect of the meniscus where there's less than optimal blood supply to encourage healing and also due to the quality of the tissue, it was not amenable to a suture repair.

Q. Okay. And before we get into your actual treatment sequelae of Mr. McDermott, I just want to ask some general questions about a meniscus.

A. Sure.

Q. Can you please tell us what is the function of the meniscus in the human knee?

A. The meniscus consists of a type of tissue called cartilage. In the knee there are two types of cartilage.

There is the articular cartilage which is the joint lining cartilage that lines the end of the bone. The two bones that come together to make the knee are the femur or the thigh, the tibia or the shin. So the joint lining or articular cartilage is one type.

The other type is the meniscal cartilage. The meniscal cartilage can be thought of as a type of gasket or shock absorbing structure that sits in between the two bones, and if I may, I can show you on this (indicating).

Q. Please, go ahead.

A. All right. You put there Exhibit No. 3. Let me get that lined up.

Q. What do we see there? Are we good?

A. Yes, sir. This is a cross section through a knee. The femur would be up above here (indicating) and the tibia would be below (indicating). So what we're looking at here is the meniscal cartilage.

Those are depicted here (indicating) in these blue, sort of semi circular rings and the lighter blue would be the articular joint lining cartilage.

So you can see how they sit in a position to help absorb shock, and the histologic makeup of the cartilage is such that it helps to absorb shock and resist an axial load, a load that goes down through the long axis of the knee.

Q. So without the meniscus at all, if it was totally removed, unless you were to as a surgeon put in some artificial cartilage or meniscus, you would have bone on bone; is that right?

A. You would have articular cartilage on articular cartilage after which point that cartilage can wear away, and then you can get to a bone on bone situation.

There is very good literature that shows that resection of a very small amount of the meniscus can increase the forces that the articular cartilage sees.

The articular cartilage can be thought of sort of like the rubber on the tire. Okay. Once it wears away, however, you can't replace it. It's gone.

Q. Okay. Let me ask you if you could do this. If you take this pen and just draw an arrow to the articular cartilage and just abbreviate like AC so we know what it is?

A. (Witness indicating.)

Q. Thank you. Of course, and then your, that's the more soft material that's in the inner portion of the knee, the articular cartilage?

A. That's in the joint lining cartilage.

Q. And articular means what?

A. Joint.

Q. Okay. And then the outer cartilage that is involved in this case is called what?

A. The meniscus. So you have one lateral and one medial, the medial being the inside part of the

knee and the lateral being the outside of the knee.

Q. Okay. Great. Thank you. Now, with respect to the mechanical forces that we as people are subjected to, are those meniscus important to cushioning the tibia and the femur?

A. Yes.

Q. And if they are damaged in some way and you remove a portion of the medial and lateral cartilage, does that reduce the amount of cushion that the person has?

A. Yes. The torn cartilage no longer functions normally. Okay. So the tear is what actually reduces the amount of available meniscus.

Q. Right.

A. Okay. The resection is aimed at decreasing the symptoms due to the torn cartilage.

Q. Why is it painful to have torn cartilage?

A. Because the kinematics or motion of the meniscus is abnormal. So when you have a torn cartilage, it doesn't react or act normally. It doesn't dissipate force the way it's supposed to, and it will pull on other structures in the knee.

The cartilage itself has no nerves in it so it doesn't cause pain. However, it can cause abnormal motion in these other structures which do have nerve

tissue and therefore cause pain.

Q. So as an orthopedic surgeon specializing in sports medicine and in knees, when you remove a portion of the medial and lateral meniscus, why does that make the patient more comfortable?

A. Because you stabilize the tissue and you leave what's called the meniscal remnant so you try to preserve as much meniscus as you possibly can, and the meniscal remnant having been stabilized can then function more normally.

Q. All right. With respect to Mr. McDermott, we have a copy here of a large portion of your file.

A. Okay.

Q. And I think the set there is marked as Frank Exhibit No. 1, and feel free to refer to any of those things.

A. Okay.

Q. I'm just going to go through some of these pages here. Okay?

A. Sure.

Q. The first page here reflects a date I believe of an encounter of 11-18-2016, and it shows chief complaint, left knee pain.

Can you just use this to refresh your recollection and tell us if this is the first time

that you saw Mr. McDermott, and when you met with him and took a history, what did you learn?

A. Yes. I believe the first day that we met was November 18th, 2016. You know, at that point, yes, he was 54-years-old, and he gave me the history of an injury to his knee. The documented history is twisted his knee while pulling hoses across a deck.

He had had imaging with an MRI done on 11-8-16 that he brought with him for review. He was complaining of a burning pain that was constant in nature. He was complaining of mechanical symptoms including clicking and popping, and on a pain scale rated zero to ten he rated it an eight out of ten.

Q. All right. So let me ask about this mechanism of injury.

A. Sure.

Q. When a person is pulling on an object and comes to you with a history of the pain, what have you learned over the years about the mechanism of injury, how a meniscus is torn doing a task where you're standing, and I want you to assume he was standing on a steel deck, that he had a hose in both hands, that he was pulling on it, and that he twisted or turned his torso somewhat.

And at the moment of injury does not recall

any extreme pain whatsoever, may recollect a twinge and then after leaving work that evening at approximately 6:00 to 6:30 p.m., awoke in the early morning hours with knee pain.

Based upon that history and your education, training and experience with patients, can you tell us within reasonable medical probability what you believe happened inside that knee?

A. So, first of all, meniscal injuries are very, very common injuries to the knee, probably the most common diagnosis that I make as a knee surgeon in my practice.

The classic mechanism of injury is a twisting injury to the knee. That can occur over a variety of activities. I see it in professional athletes. I see it in small kids. I see it in -- there are all different types of ways the knee can twist.

The meniscus, the way the collagen fibers are organized in the meniscal tissue makes the tissue very, very sound and hearty in compression. Okay. It has collagen that's organized in a way that it can develop hoop stresses and dissipate force in axial load.

Q. When you say hoop stresses, what do you mean?

A. It's a term in physics and in engineering

that the axial load is dissipated throughout the meniscus.

Q. Sort of like in a spherical manner?

A. Yes, circumferentially. Circumferentially organized collagen fibers.

Q. Okay.

A. Because of the organization of the collagen fibers within the meniscal tissue, the tissue is also very vulnerable to shear, so, you know, as opposed to an axial compression, shear has some twisting component to it. All right.

So the classic mechanism is a twisting injury to where the foot is planted and the rest of the body twists.

Again, you can imagine you could see this in a soccer or a football player, but you can also imagine it in Mr. McDermott's case where he's carrying a hose or something that I presume has some weight to it or some mass.

His foot I would imagine to be fixed on a ship deck and he is twisting so there's your shear force across the knee.

So based upon his complaint of pulling a hose, it's a reasonable mechanism for the type of injury he had.

Q. Okay. So based on what he told you, was that consistent or inconsistent with histories you had of other people that had a report of a knee injury while doing something with their knee twisted?

A. I think it's consistent.

Q. Okay. And then at that time when you saw him, you related to us he had an MRI run prior to coming in, and do you remember from your treatment of him what the MRI reflected?

A. He did. The MRI, the primary diagnoses from the MRI were a tear involving the body and posterior horn of the medial meniscus, the one on the inside of the knee, a small tear involving the lateral meniscus or the meniscus on the outside part of the knee, as well as some minimal arthritic change. Those were the primary diagnoses obtained from the MRI imaging.

Q. Okay. When I read through the file, there's something called the lateral meniscus horn. Can you show us on the diagram on the camera where that is at?

A. So, you know, in general the meniscus is broken up into several segments, so if we're looking at the lateral meniscus, from about this (indicating) point to this (indicating) point is called the body of the meniscus.

In anatomy anterior means front and posterior

means back. So the anterior horn would be from this (indicating) junction of what we would consider the body right here (indicating) to about right here (indicating). This is the body, and this would be the anterior horn and the posterior horn. Okay. These meniscus are also rooted.

I guess we have an anterior root and posterior root. So those are anatomically of what we look at as the division of the meniscus.

Q. Okay. So in this stack of paper here, if you turn to, it's probably the fifth or sixth sheet. It's marked page 19 at the bottom.

A. Okay.

Q. And if you look through here in the one, two, third paragraph --

MR. DeGIULIO: Mr. Morgan, do you have a date of the report?

MR. MORGAN: Yes, sir. This one is dated description of operative procedure, and at the top it says opt note signed by Darren Frank, M.D., 12-7 of '16.

MR. DeGIULIO: Okay.

BY MR. MORGAN:

Q. In that third paragraph you're basically dictating I presume what you saw when you did surgery

on Mr. McDermott; is that right?

A. Correct.

Q. Okay. And can you explain to the jury before you're actually doing the surgery what happens to Mr. McDermott to prep him, and is he under general anesthesia?

A. Sure. So these procedures are done as an outpatient. I believe the surgery was done at Allegheny General Hospital. The patients are first seen by a physician extender, either a nurse practitioner or a physician's assistant.

They're prepped for surgery. IVs are placed to facilitate anesthesia. They're seen by the anesthesiologist who's working with me that day.

These surgeries are typically done under what is called local sedation so they will be given a sedative through an IV which essentially puts them into a sleep, but they still control their own breathing and respirations.

They are monitored by either an anesthesiologist or a nurse anesthetist who monitors their vital signs as well as their well-being throughout the procedure.

The local part of local IV sedation is done on my part by either anesthetizing them with a local

anesthetic. It's done through an injection once they're in the operating room.

So once they're prepped they come back to the operating room. They're given a little bit of medication through the IV to relax them and to start them off to what's essentially a twilight sleep.

Under sterile conditions we then inject several milliliters of local anesthetic into the joint to help anesthetize it and make it as pain free as possible.

The extremity that we're operating on then is prepped and draped and using the usual sterile techniques to avoid any infection risk.

We do the surgery with tourniquet control meaning that we limit the amount of blood flow into the limb during the extremity. These operations vary in time. The amount of safe tourniquet time is less than two hours. This tourniquet time is listed as 25 minutes.

So once everything is prepped and we're sterile and ready to go, the surgery is done arthroscopically which means the two small incisions are made in the knee, and we use a camera to visualize inside the knee.

Q. With a tube?

A. With a tube, yes. So we insert a tube or a trochar into the knee.

Q. Okay.

A. The camera is inserted through there. We are able to visualize the knee through very, very small incisions.

Q. Okay. So obviously what you're saying it's not an open knee surgery?

A. No.

Q. Where you cut the flesh and down to the area?

A. No. It's two small incisions.

Q. Okay. And then why don't you just walk us through paragraph three --

A. Sure.

Q. Of what you did to try to help Mr. McDermott?

A. So going through some of those operative findings, we noted minimal chondromalacia. Chondromalacia is another term for articular cartilage damage or arthritis. So minimal in the patellofemoral joint. That's underneath the kneecap.

We noted synovitis which is the synovium is the lining of the joint. Synovitis occurs for a variety of reasons, either posttraumatic arthritis, so it's just an inflammation of that tissue.

So we made a second portal or the first

portal or a small incision and put the scope of the camera in. We performed a synovectomy meaning we resected some of that inflammatory tissue.

It says the ACL was grossly intact to inspection, as well as probing. The ACL stands for anterior cruciate ligament, one of the four major stabilizing ligaments in the knee. There was no issue with that.

The next point of inspection is the lateral compartment. That's the outside compartment, and I did note there was a tear involving the anterior horn of the lateral meniscus.

Q. Let me slow you down here. When you talk about the anterior horn, is that -- you've already shown us.

A. Sure.

Q. You said right here, the anterior horn (indicating).

A. That's correct.

Q. And was the root of the lateral meniscus involved?

A. No.

Q. Okay. And what portion of that anterior meniscus did you remove?

A. A small amount. So we noted that it was a

short radial tear, and I quantified that as about 15 percent of the anterior horn and body of the lateral meniscus, so a small amount, meaning that 85 percent of the meniscal substance remained after resection of that tear.

We also noted some degenerative changes on both sides of the joint in that compartment, in the lateral compartment.

Q. And what does that mean?

A. It means that the cartilage was damaged.

Q. Okay. And so is there a way for you to tell when you're doing your arthroscopic surgery looking at the inside of the knee through the camera for how long that cartilage had been damaged?

A. It's difficult to say but this, the cartilage damage, and now we're talking about the articular cartilage, not the meniscus.

Q. Okay. So now the articular cartilage, you got the AC right here (indicating), these two spots; is that correct?

A. Yes, and if we slide this (indicating) down a little bit?

Q. Uh-huh.

A. All right. Are we focused there? So this is now a coronal view of the knee looking at it from the

front.

So imagine if we took the other picture and rotated it back about 90 degrees. This (indicating) blue here represents the articular cartilage, and you can see the meniscal tissue that sits in between here (indicating) as a shock absorber. So this is what I'm talking about when I describe Grade I through Grade IV changes.

Q. Uh-huh.

A. Of the knee. So when we document Grade II and III changes, those are, that's a grading scale that we use to quantify articular cartilage damage.

And in my opinion in Mr. McDermott those were not acute injuries. That was due to some arthritic change that we knew he had, as well from MRI and x-ray.

Q. So it would be like wear and tear?

A. Wear and tear.

Q. And that's, what you're pointing at here is the same thing as we see over on the other picture that we showed earlier?

A. That's correct.

Q. Which is this stuff here (indicating), the articulating part?

A. That's correct. You have it on both sides of

the joint.

Q. And that's not the part you did surgery on?

A. That's correct.

Q. Okay. Got it. All right. So when you compare the amount of damage that was done to the anterior meniscus to the damage done to the medial meniscus, which was worse?

A. The medial meniscus was more severely affected.

Q. Why don't you tell us what was the amount of medial meniscus that you had to remove?

A. So in the medial meniscus we noted a tear involving the posterior horn and extending to the root in those terms I described earlier.

Q. Okay.

A. There was some maceration which means that the meniscus was sort of grinding down so there were components there that, you know, when a meniscus is torn and somebody walks on it, it gets macerated.

Q. Okay.

A. Or, you know, that's a term we use, or ground down. There was also what we documented a horizontal cleavage tear which is a tear that goes almost through the meniscus through the tissue.

We noted the tear extended to the root but

did not involve root detachment, and it was described as a central tear meaning that it was not vascular.

So what we talked about earlier about the types of surgery that are done on the meniscus, whether it's partially resected or whether it's repaired depends on these findings.

These are what I'm judging as a clinician and as a surgeon as to what the most appropriate operation is.

Based upon these criteria, I thought a partial resection was more appropriate because putting stitches in this type of tear would not work.

Q. Okay. And so, Doctor, in your training and in your experience as a knee surgeon have you studied and come to learn whether when you have damage to the knee meniscus root as he had is this considered by you to be a serious injury to the meniscus?

MR. DeGIULIO: I'm going to object to the form of the question.

MR. MORGAN: I will rephrase it.

Q. Tell us what is the significance, if any, to the type of injury that Mr. McDermott had to the medial meniscus.

A. So it's a significant injury in that a substantial portion of the meniscus had to be removed

in order to treat him. So the meniscal roots were stable, but he had a tear of the posterior horn, which again we've gone over a little bit of that anatomy already.

So it's substantial in that the meniscus was torn and irreparable and therefore the only way to treat it and alleviate the symptoms is to resect the torn part.

Again, we know that biomechanically resection of a very small amount of the meniscus can increase the forces significantly, but that was the treatment the injury required.

Q. Okay. I have this article that was published in the Iowa Orthopedic Journal. The title of it is Medial Meniscus Root Tear in the Middle-Aged Patient. I want to read something from this and ask you if you have an opinion as to whether this is true.

It says, "Posterior root tears are also more biomechanically significant, as they can disrupt the essential shock absorbing ability of the meniscus and render it unable to adequately transfer axial load into hoop stresses."

MR. DeGIULIO: I object to the question. The doctor's testified that there was no involvement of the root. You're reading from an

article about root tears and a sentence about the effect of a root tear.

BY MR. MORGAN:

Q. Well, let me see. Let me back up here and lay a little bit of foundation. In a medial meniscus was there a tear there at the root or not?

A. There was a tear that involved the root without root detachment.

Q. Okay. So does that reduce Mr. McDermott's ability as he walks to shock absorb the forces on the knee joint?

A. The resection of the meniscus that was performed would result in increased forces and decreased shock absorption.

Q. All right. So if he were to continue to engage in work that he had chosen as his method of earning a living, working in maritime positions where he walks, he occasionally kneels, and he climbs ladders during the day on steel decks, steel stairs for anywhere from eight to say ten hours per day, is he going to be in pain because of this injury?

A. Well, all of his activities are activities that would put a fair amount of force across the knee as opposed to more sedentary activity. Therefore, given the fact that some of his meniscus were injured

in addition to the arthritic change that he already had, I would say that those activities would be aggravated.

Q. Okay. And within reasonable medical probability when you say those activities would be aggravated, what are the manifestations of doing it? What does it do to him?

A. Pain would be one. Stiffness, swelling. Those would be the type of symptoms that I would expect him to have.

Q. And over the period of time that you treated him, if you refer to your records and prior to coming in here today we had a meeting, did you refresh your recollection about the treatment to Mr. McDermott?

A. I did.

Q. I believe one of the documents shows a visit of 5-16 -- I'm sorry, of 5-6 of '18, in May of this year.

A. It was May of this year. I don't recall the exact date.

Q. Okay.

A. But, you know, from the time of his surgery I followed him for approximately 18 months.

Q. Okay. Is it pretty typical for this type of surgery?

A. It's not entirely typical because he's had some issues during his recovery.

Q. Okay. And have you had to inject him with cortisone over the period of beginning February 17th, '17 through May 6th of '18?

A. I believe he's had treatment with cortisone on three occasions since his surgery.

Q. Roughly eight months apart?

A. Roughly eight months apart.

Q. And was that at your direction?

A. It was.

Q. And for what reason did you offer him and he accepted injection of cortisone into the knee?

A. Continued complaints of pain and the diagnosis that for me postoperatively is now osteoarthritis.

Q. And what does that mean?

A. Osteoarthritis is the wearing away of that articular cartilage, the wear and tear.

Q. Okay. And the articular cartilage is the more soft cartilage if we look at the diagram where you marked?

A. It's not actually softer. It's the type of cartilage that lines the joint.

Q. Okay.

A. Okay. So it's -- it lines the end of the bone.

Q. Okay. So if he were to continue, Doctor, to perform work where he walks on steel decks, climbs ladders occasionally, stoops and bends, kneels occasionally in his work and does this day in and day out, within a reasonable medical probability is he at a risk of increasing his osteoarthritis?

A. In my opinion those activities would be aggravating and those types of activities could result in worsening of the arthritic condition.

Q. Okay. And is that consistent with what your medical practice has shown for people who do this and have this kind of operation?

A. Yes.

Q. Okay. Now, I don't want to go through every page of your treatment of Mr. McDermott, but I do want to cover some of the pictures that we have.

I did photocopies of the internal photographs that you had of the meniscus, and I believe if we look at those, it begins at Bates page number 64 at the bottom which you should have there. It looks like the date that this scan was run was 12-6-16.

Was this done at the same time you did the surgery?

A. Yes. Those are live photos of the arthroscopic procedure.

Q. All right. And if you could just go through those, pick the ones you believe fairly and accurately depict the conditions that caused you to resect the portion of the lateral and medial meniscus?

A. All right. So this is going to be arthroscopy page two.

Q. Okay.

A. We're looking at the top left photo here. This (indicating) one right here.

Q. Okay. What does that show?

MR. MORGAN: You got it? Towards you? Come this way a little bit. That's good?

A. So this (indicating) is the lateral meniscus. This depicts a tear. It's a bit hard to see because this is a photocopy.

Q. Sure.

A. Of an image generated out of our electronic medical record, but this is the tissue right here and this is the tear (indicating).

Q. The dark spot's the tear?

A. Right in here (indicating), yes.

Q. Okay.

A. And then this is the picture after the

resection. You can see that portion of the meniscus has been removed right along this resection line here (indicating), and now it's smooth again.

So, you know, there's no longer an edge to catch. The meniscus has now been stabilized. That's the partial meniscectomy, the partial lateral meniscectomy on the outside part of his knee.

Q. Is that portion here that we see in the bottom of this part, it seems wider than right here. How did this become more closed like that (indicating)?

A. Which part are you looking at?

Q. Right here after you resected it, it seems like the darkened spot is not as wide as it was before surgery.

A. I mean that's a shadow from the light.

Q. Oh, okay. So basically would it be fair and accurate to say what you're trying to do is remove any frayed or jagged parts of the meniscus?

A. That's correct. That's correct.

Q. Okay. And the reason is because the meniscus is a cushion between the tibia and the femur?

A. Right. As we talked about the portions that are torn become unstable and so as the knee is placed in a range of motion, the meniscus moves abnormally.

There's abnormal meniscal motion.

Q. Okay.

A. Which can result in pain.

Q. Okay. So now we've covered the lateral meniscus which is on page 65 dated -- let's see if there is a date on this. Yes. 12-6-16 at 3:01 p.m. And do we have one of the medial meniscus?

A. On this set of records there's a page missing from the arthroscopy. I have one, two and four. I don't have page three.

Q. Okay. Sorry.

A. But at any rate --

Q. You know, in your chart -- you might have it in your whole chart there. Did you bring it in?

A. I didn't bring the arthroscopic images in. I'm sorry.

Q. Okay.

A. But this image right here I'm looking at, this (indicating) one.

Q. Yes, sir. Are we okay? Does that have to come this (indicating) way? Okay.

A. So these are difficult to see. I mean these are not ideal images to do any sort of teaching from. However, this is the torn meniscus right here (indicating).

Q. Okay.

A. And this is the tear in the posterior horn right there and this is the before and these are the after pictures so you can see again stabilized meniscus removed any loose edges or torn fragments from the meniscus (indicating).

Q. And that again is on the lateral side?

A. That's the medial side.

Q. Oh, that's the medial side. Okay. That one is Bates stamped 67, the same date, 12-6-16.

A. Yes.

Q. All right. Thank you. Okay. So if you go to page 82 in these records, this shows a history he came back about a week after knee surgery, and was there anything remarkable about this visit?

A. Yes. He had had some issues immediately postoperatively that necessitated a visit to the emergency department. I believe the surgery was 12-6. Is that accurate?

Q. I believe so.

A. So three days later he had some pain and unfortunately, the office was closed so he sought care in the emergency department. They tried to aspirate his knee which is to draw some fluid out of it. They were not able to indicate any evidence of an

infection.

Despite that early episode of early postoperative increase in pain, by the time he was a week out when I saw him on the 14th, he was feeling somewhat better. I did note some pain and denied any infection symptoms.

Q. Okay. So in the ensuing weeks just to put this in perspective, what did you encounter as far as his progress and any specific complaints he may have made?

A. Yes. I mean we followed him as we would any other postoperative patient. He was advised to limit his activity. He was kept out of work for that reason.

We started him in a course of physical therapy and rehabilitation and joint mobilization, just general rehab of the muscles around the knee.

He was treated initially with pain medication. I don't know the exact duration of time that he took pain medication, but we followed him for the usual postoperative course which for this type of operation is roughly two months, give or take.

Q. Okay. During that period of time if we were to go into the nuts and bolts of what you wrote, would it be accurate to say that there were times where he

was pain free and doing well and there were times where he had complaints of pain?

A. I can't comment as to whether he was pain free but your statement as to there were times when he was doing what I would call well as opposed to times when he was doing less is accurate.

He had sort of a vacillating course where sometimes he would come back to the office saying he was doing well in terms of his symptoms, and there were other times he was still complaining of symptoms. That's accurate.

Q. Okay. And what is the basis? What's the cause of the person that has this type of surgery to have that sequence of events following surgery?

A. Typically, it's the arthritic symptoms so the efficacy of this type of surgery, the ability to do what it's aimed to do is inversely proportionate to the amount of arthritis that a patient has.

So a patient who has a very arthritic knee which Mr. McDermott did not have a very arthritic knee and has a meniscus tear would likely not be offered surgery in my practice because my ability to effect a change in that knee is minimal.

Q. I see. Okay.

A. However, somebody who has mild to moderate

arthritis, some Grade II and III changes as we noted at the time of arthroscopy, somebody who has pain due to arthritis, as well as a meniscus tear, it's very difficult to tell preoperatively what is causing his symptoms because symptoms are very, very similar sometimes.

So it is not uncommon for somebody with some arthritic change to require further treatment of their arthritic condition even beyond a successful treatment of their meniscal tear.

Q. Okay. So let me ask you this, you know, if a question is presented to you did he have some degree of arthritis before the injury?

A. I mean the answer to that question would have to be probably almost certainly because those changes don't develop in a very short period of time. I did not think the articular cartilage injury acute. So the answer to that would be yes, in my opinion.

Q. Okay. Is that typical of a man that's done laboring type activities at age 54?

A. Yes.

Q. Okay. And second to that is do you have an opinion within a reasonable medical probability, the incident of 10-29-16 where he's pulling on a hose and twisted it, aggravated the underlying arthritis?

A. In my opinion, yes.

Q. Why is that?

A. Arthritis exists and as we've mentioned, the cartilage has very little nervous tissue in it so arthritis hurts for a number of reasons. There is mechanical forces that affect the bone which is very rich in innervation and can cause pain.

Q. Right.

A. Obviously, a broken bone hurts, right, because there's nerves in it. So arthritis doesn't hurt like a broken bone but it does hurt because the forces of the bone cease.

This can be exacerbated by meniscal injury which as we've talked at length about has decreased the amount of shock absorption that the meniscus is normally designed to perform.

In addition to those mechanical forces on the bone there's a biological phenomenon that causes pain. There is inflammatory markers that are released within a joint when there is arthritis that causes pain.

And that's why medical treatment such as injecting cortisone can interrupt those cascades, those biologic phenomenon and effect relief of arthritic pain.

Q. Okay. So when you talk in terms of

biological phenomenon or issues, is it important that either through cortisone or analgesics, to any inflammatory medications that you stop the inflammation?

A. I mean it depends. I mean, you know, there is some degree of inflammation at all times in the body, but when it becomes symptomatic, yes, we try to arrest that. Antiinflammatory medications are one way to do it. Those are taken orally. They're nonsteroidal. They're steroidal.

Q. Right.

A. There are different types of injections, things that we can inject into the joint to affect that local environment with less side effect on the whole portion, and cortisone is one way that that's done.

Q. Okay. And you already said you did three separate cortisone injections into his knee over that period of time we discussed.

A. Uh-huh.

Q. Within reasonable medical probability do you have an opinion whether he will continue to need steroidal injections from time to time?

A. It would be my opinion based on his history that yes, he probably would.

Q. And is that for the purpose of removing or trying to lessen the amount of inflammation?

A. To control inflammation along with his degenerative condition.

Q. And the motivating force of that is to relieve his pain?

A. Yes.

Q. Taking aside the necessity for everybody that's not independently wealthy and we earn a living and setting that over into say column B as not part of the consideration, as far as a recommendation for what is best for Mr. McDermott relative to his injured knee, should he attempt to find employment other than the craft of having to perform laboring tasks where he climbs ladders on occasion, stoops and kneels on occasion and walks on steel decks as he does in the maritime industry?

A. Well, in addition to the type of treatment that I can provide as a physician and a medical provider, and we alluded to many of those, many of the things, many of the interventions that I can provide to try to mitigate the symptoms of arthritis, in addition to those, there's also activity modification.

So somebody with an arthritic knee, I usually recommend they modify their activity, whether it be

exercise, activities of daily living or work.

Q. Yes.

A. So the conditions that you mentioned that Mr. McDermott works in that require those activities that you mentioned, it would be my recommendation that he limit those activities because those activities could be aggravating to his knee.

Q. Okay. And just to kind of finalize and to kind of wrap things up here, you submitted I believe two narrative reports, one November 15, 2017, and kind of summarized what has happened to Mr. McDermott, and I believe this was before the surgery which was done December 6th of '16. Oh, wait. I'm wrong. This is November 15, 2017, so this is about 11 months post surgery.

A. Yes.

Q. And then I believe you did another narrative report in May of this year.

A. Okay.

Q. Okay. So can you just verify that those were your dictations and your reports pertaining to the patient?

A. They were.

Q. Okay. And other than that, I believe one of the things I would love to do if we can is get a copy

of your bill and attach it as an exhibit to the deposition. We don't have to do it immediately but sometime before I leave today, and I need to ask you this question.

Are the billings that you do here in your practice in conformity with and consistent with what practicing physicians in your level of skill and professional services charge in this community?

A. Yes.

MR. MORGAN: Okay. Thank you very much. I will pass the witness.

MR. DeGIULIO: Did you mark a series of exhibits already? You hadn't referred to any exhibit numbers.

MR. MORGAN: Yes. We marked the exhibits that I was going to do my direct examination from as Frank No. 1 in global which I gave a copy to you.

MR. DeGIULIO: I actually don't have a copy. This is different from those, but that's okay.

MR. MORGAN: You can take these. I'm through with them if you want to use them.

MR. DeGIULIO: I'm just going to mark those.

MR. MORGAN: Okay. And then we also marked these exhibits as three, two, five, four which are depictions. He testified to all of them.

And you're right. We should mark the tears that we referred to as exhibits, and I think there was two of them. I'm going to have to since we didn't mark those, and we can go back into the record.

MR. DeGIULIO: Sure.

MR. MORGAN: Get the court reporter to help us.

MR. DeGIULIO: I just want to know what you marked.

MR. MORGAN: No. I agree. We've got to keep track of our stuff.

MR. DeGIULIO: Okay.

MR. MORGAN: Yes. Let's go off the record a second. She's been typing.

VIDEOGRAPHER: We're going off the record. The time is 5:19 p.m.

(Off the record.)

VIDEOGRAPHER: We're going back on the record. The time is 5:23 p.m.

(Frank Deposition Exhibit No. 6 was

marked for identification.)

(Frank Deposition Exhibit No. 7 to be marked at a later time.)

EXAMINATION

BY MR. DeGIULIO:

Q. Good afternoon, Dr. Frank. Thanks for your time today. We put in front of you what we've marked as Exhibit 8 which is a compendium of all the records in the case.

A. Yes.

Q. Okay. And I will be referring to various documents.

A. Okay.

(Discussion off the record.)

MR. DeGIULIO: Let's just mark this. What are we at? Seven?

THE COURT REPORTER: Seven is going to be the bill we're going to mark so this will be --

MR. DeGIULIO: Eight.

THE COURT REPORTER: Eight.

Q. Dr. Frank, I will just represent to you that --

(Off video portion of record.)

THE COURT REPORTER: Wait.

MR. DeGIULIO: Oh, I'm sorry.

THE COURT REPORTER: Wait. Hold on a second.

(Frank Deposition Exhibit No. 8 was marked for identification.)

MR. DeGIULIO: I will tell you off the record this is just a compendium of your reports that I put together for this deposition.

VIDEOGRAPHER: We are going back on the record. The time is 5:23 p.m.

BY MR. DeGIULIO:

Q. Good afternoon, Dr. Frank. Thanks for your time today.

A. Okay.

Q. I put in front of you what we've marked as Exhibit 8 which is a compendium of both of your reports that I put together.

A. Okay.

Q. And I will be referring to those documents.

A. Okay.

Q. Have you read any witness testimony from the lawsuit?

A. Not to my knowledge.

Q. Okay. Have you been provided by Mr. Morgan with any documents relating to the lawsuit itself other than medical documents?

A. Other than a conversation, no documents.
Q. You had a conversation with Mr. Morgan?
A. Yes.
Q. When did that occur?
A. Today.
Q. How about prior to today? Have you spoken to Mr. Morgan?
A. I believe we had either a telephone or face-to-face conversation at some point.
Q. Within the last year?
A. Within the last two years.
Q. Okay. When did you first learn that Mr. McDermott had an attorney?
A. I can't say exactly. I don't know exactly.
Q. When did you first learn that Mr. McDermott filed a lawsuit?
A. I don't know that either.
Q. I'm going to show you a couple of exhibits just so the jury might be able to better understand all of the medical terminology we're talking about.
A. Okay.
MR. DeGIULIO: And if you could mark this one as nine? What are we up to? Nine?
THE COURT REPORTER: Nine.
(Frank Deposition Exhibit No. 9 was

marked for identification.)

MR. DeGIULIO: And this one as ten.

(Frank Deposition Exhibit No. 10 was marked for identification.)

MR. DeGIULIO: Did we get these marked yet?

BY MR. DeGIULIO:

Q. So Exhibit 9 is just a discussion, an article I pulled off the internet.

A. Okay.

Q. What I want to ask you about on the first page here is this seems to suggest that there's two causes of meniscus tears, one related more to what I would call trauma, sports injuries, that sort of thing, and a second category of degenerative knee causes.

Am I correct based on my reading of the literature that if there is osteoarthritis present in the knee, that the risk of a meniscus tear goes up?

A. I'm sorry. Repeat that one more time.

MR. DeGIULIO: Could you read it back?

(The pending question was read back.)

A. That is correct.

Q. Okay. And could you tell, you made mention of this in your testimony, degenerative osteoarthritis

is graded; is that correct?

A. That's correct.

Q. How many grades are there?

A. I through IV.

Q. Okay.

A. Those are average. The eponym for that particular grading is I through IV.

Q. And that's IV being the worst?

A. The worst. Exposed bone would be IV.

Q. Okay. Could you look at the second part of what I marked again off the internet, and I'm not asking anything more than some generalities here?

A. Okay. Sure.

Q. Could you look at the top of the second page of this document, Exhibit 10? There are some drawings of tears. Do you see that?

A. Yes.

Q. Are you able to use these drawings to tell me is any one of these an example of what you saw with Mr. McDermott?

A. So, sure. The bottom left is an example of a radial tear. That's what he had laterally on the outside part of his knee.

Q. Right.

A. The tear on the medial meniscus was more

complex meaning he had multiple types so it's more an amalgam of these types. I would say a combination of the bottom right and the top right.

So there was a displaced flap and there was also some -- you could see the one depicted, labeled there as a degenerative tear. There's some fraying or abnormality of the central aspect of the meniscus. So I would say it's a combination of this.

Q. Okay. So that's what you saw on the medial?

A. On medial.

Q. Right. So part of what you saw was a degenerative tear?

MR. MORGAN: I object to the form of the question.

Q. Go ahead. I think that's what you just testified to.

A. This label, this is overly generalized, the label, so.

Q. But you did see fraying?

A. I saw fraying, but that does not make it a degenerative tear.

Q. Okay. Could you look under the word cause here right down the middle of the page?

A. Sure.

Q. I'm going to read it, and I'm going to ask

you if you agree with it.

A. Sure.

Q. Older people are more likely to have degenerative meniscus tears. Do you agree with that statement?

A. Yes.

Q. Cartilage weakens and wears thin over time.

A. Yes.

Q. Do you agree with that?

A. Yes.

Q. Aged, worn tissue is more prone to tears. Do you agree with that?

A. Yes.

Q. Finally, just an awkward twist when getting up from a chair may be enough to cause a tear if the menisci have weakened with age.

MR. MORGAN: Object to form.

Q. Would you agree to that, with that statement?

THE WITNESS: Can I answer?

MR. MORGAN: Yes, please.

A. Yes.

Q. Throughout the time that you followed Mr. McDermott, what has he told you about his return to work in the dredging industry?

A. We talked about -- we talked about return to

work in the setting of the medical condition of his knee. So our visits are not aimed at discussing his lawsuit. They're really focused on his knee and the quality of the health of the knee.

Q. Uh huh.

A. So we have returned Mr. McDermott on at least one occasion that I am aware of back to full work duty.

Q. Uh-huh.

A. And he has been able to go back to work but has complained of pain doing the type of work that he does.

Q. Uh-huh. Did he -- would it have been important to you during this period of treatment to know exactly how many times he went back to work and what he did?

A. We discussed what he did, and so that's part of -- now I'm aware that he works offshore on a ship and, you know, I'm going to be very general here because my knowledge of his work is general. I'm aware that he does labor that requires him to lift, squat and climb.

Q. Uh-huh.

A. And, you know, I could probably go back in the medical record and note from the standpoint of his

medical visits how many times he went to, and went back to work, but I don't know that off the top of my head right now.

Q. Well, let me ask it a different way. I've gone through all your reports and records.

A. Sure.

Q. And on one occasion after you returned him to work in May of 2017, he came back to see you in August after he worked, and he told you about the work.

A. Yes.

Q. Okay. Now, that's the only reference I see to any discussion about him having gone back to work in the dredging industry.

A. Okay.

Q. So that's why I'm asking you the question. Did he continue to tell you what he was doing, how he was working, and where he was working?

A. I don't think beyond that one discussion. Not that I can recall.

Q. Okay. How much do you know about the dredging industry?

A. Very little.

Q. Okay. And I presume therefore that beyond what Mr. McDermott might have told you, you don't have any independent knowledge about the types of jobs that

are available in the dredging industry?

A. That's correct.

Q. And you don't have any particular independent knowledge of the demands of those jobs or the forces on the body?

A. No. No.

Q. Did he ever tell you there is jobs in the dredging industry that don't involve working on vessels?

A. He did not.

Q. And he didn't tell you that actually he went back to work and worked on one of those jobs?

MR. MORGAN: I will object to the form of the question.

A. Not to my knowledge.

Q. If you could look at tab one, this is your report of your first encounter with Mr. McDermott, November 18th, 2016, and Mr. Morgan I think already asked you some questions about this.

A. Okay.

Q. If you could turn to the second page on the report?

A. Uh-huh.

Q. At the bottom which is a description of what Mr. McDermott told you?

A. Uh-huh.

Q. I just want to understand and make sure the record's clear. You have no independent knowledge of anything having to do with how, when or where he was injured other than what he told you; is that right?

A. That's correct.

Q. Here and elsewhere, here in this same paragraph, you say pain is localized medial, but I just want to ask you more generally about pain.

Do you agree with me that there is no objective test to evaluate a patient's pain?

A. There is no complete objective measure for pain, correct.

Q. Do you agree it's really subjective and based on the reports of the patient?

A. Yes.

Q. So any time you're talking about pain in these reports, just as with any other medical reports, that's based on a description of what the patient is reporting to you?

A. That is correct.

Q. Can you tell me again how did you grade the extent of the osteoarthritis that you saw in his left knee?

A. Grade II and III.

Q. And is that mild to moderate?

A. It would be -- I mean I would call it moderate. Grade I, I could call mild. Grade II and III moderate and Grade IV severe.

MR. DeGIULIO: Could you mark this, please? I don't have extra copies of this. Sorry.

(Frank Deposition Exhibit No. 11 was marked for identification.)

Q. If you can just take a look at what I found on the internet marked as Exhibit 11?

A. Sure.

Q. This seems to relate to this concept that you've been describing about the grading.

MR. MORGAN: Object.

Q. To the extent of degradation of a knee.

MR. MORGAN: Objection, form.

Q. Am I correct about that? Is this the scale that you're talking about?

A. It's similar. Yes.

Q. Okay. Is this something different? I just want to make sure I understand.

A. No. It's similar.

Q. Okay. Could you read the descriptions of the --

A. Grade 0, normal. Grade I, yellow discoloration. Grade II, softening and unevenness. Grade III, fasciculation and attrition. Grade IV, and then they go on to subcategorize Grade IV as A, B, C, but erosion, ulcer down the bone and eburnation of the subchondral bone, and then they have Grade V, bone destruction.

Q. When you first evaluated Mr. McDermott --

A. Let me just say this. This article which I've never read before, this sounds like they're proposing a grading, a grading system which expands upon the outer ridge.

Q. Okay.

A. Which is commonly used in orthopedics. This is from an article from Japan so this is something I've never read before now. It's also from 1993 which is quite antiquated at this point. So I will tell you that this grading system created in 1993 is not part of orthopedic practice today.

Q. Where would I go to actually find in writing this grading system?

A. You can go to an orthopedic book.

Q. Okay. Now, you mentioned when you were testifying in response to Mr. Morgan's question that you observed during the procedure maceration of the

medial meniscus.

A. Yes.

Q. And I think you said, he didn't ask you many questions about it, but as I understood your testimony, you were saying that that is a symptom of having walked on the knee?

A. That's one thing that could cause it. Sure.

Q. Well, that's what I'm trying to understand. What is your opinion about what caused this maceration you saw?

A. There are many things. I can't offer an opinion.

Q. Okay.

A. There are many things that could cause it.

Q. Okay. Now, during your initial treatment of Mr. McDermott and up through and including your surgery --

A. Yes.

Q. Is there any empirical evidence that you could deduce that would tell you the timing of this injury, when it occurred?

A. No. So there's no objective measure that can, that can age a meniscus tear.

Q. Okay.

A. As clinicians, we base it on the history.

Q. Which is what Mr. McDermott told you?
A. Provided, yes.
Q. That's all you can do; right?
A. That's all you can do.
MR. MORGAN: Frank, let me make sure you don't still have the picture of the meniscus on there.
Q. Could you turn to tab three in this exhibit, please?
A. Sure.
Q. This is your report of February 17th, 2017, a couple months after the surgery.
A. Okay.
Q. And if you could turn to the fourth page which describes a plan? Do you see that?
A. Okay.
Q. So you say you're recommending additional physical therapy. You're focusing on work hardening.
Could you just tell the jury what that means, work hardening?
A. So in physical therapy and rehabilitation, in full disclosure, I'm not a therapist. However, my understanding of the way that rehabilitation functions, there's rehabilitation getting somebody back to function to allow them to do ADLs or

activities of daily living.

So that generally involves joint mobilization, range of motion, stretching and strengthening to make a joint functional.

Beyond that for somebody who has to work, for instance, somebody who has to work in an austere environment, there is work hardening. So what work hardening does is a series of rehabilitation exercises or stations, for lack of a better term, to try to mimic what he would do in his job.

So he would provide, you know, information to a therapist. This is what I need to do, and he would have him do it for an hour, that sort of thing, to try to build up a tolerance to that type of work.

Q. Okay. Did you in fact recommend that he undergo that kind of physical therapy after this appointment?

A. I believe I did.

Q. Okay.

A. Yes. Will get him into work hardening. Yes.

Q. And then near the end of this paragraph, I think it's the second to the last sentence, you say if after another month he is not ready to return to full work duty, I may consider a functional capacity evaluation to get some object of -- I think you meant

objective measure.

A. Correct.

Q. Of what it is he can and cannot do so we can provide that to his employer.

A. That is correct.

Q. What is a physical capacity evaluation?

A. It's another rehabilitation exercise where they put a subject or a patient through a battery of tests and then try to come up with a U.S. Department of Labor category that matches their ability in that test.

Q. Now, if you look at tab four, it looks like he came back in about a month, March of 2017.

A. Correct.

Q. Is this your report from that visit?

A. It is.

Q. Okay. And if you go to the second page under plan again, again it says I'm recommending work hardening and physical therapy. They will focus on squatting, climbing steps and ladders. They will see him back in another four months. At that point if he is not able to return, we'll get a functional capacity evaluation.

So did you make a determination between February and March that he should just continue for a

while in physical therapy? It seems to be the same plan. That's why I'm asking.

A. It's a very similar plan, so, yes, I'm trying to give him -- I'm trying to give the patient some time to recover. So at this point he is three months after his surgery which is still a very reasonable amount of time in my mind to recover.

So I'm trying to balance getting him back to work with treating the patient. You know, that is a little bit of an art in dealing with workers' compensation, and that was -- I have no objectivity behind that decision, but that was my opinion medically.

Q. That's fine. Go to tab five now, and I think this is a month later, April 14th, 2017.

A. Okay.

Q. Those are your notes of that visit; right?

A. That's correct.

Q. Okay. If you go to the second page, and in the second line there's a sentence that begins from. It's from the standpoint of pain he is doing very well. He no longer has any pain in his knee.

A. I'm sorry. Which page are we on?

Q. I'm sorry. It's the second page of your April 14th report.

A. Second page.

Q. Tab five at the bottom of the page. Second page. I'm sorry. Down here (indicating).

A. Got it. From the standpoint of pain. Yes.

Q. So in April of 2017 when he came to see you, he told you he had no pain?

A. That's correct.

MR. MORGAN: Which tab is that? Five?

Q. Okay. And then if we look at page three, at this visit he said I recommended additional therapy, work hardening. I'm recommending a functional capacity evaluation, as well to get some objective measure of what it is he can and cannot do.

Do you remember after this visit whether you actually put in that order for the FCE?

A. We did. He eventually had one. I don't know at what point exactly.

Q. Well, you're going to see it on the next tab.

A. Yes.

Q. I think.

A. Yes.

Q. Is that your results of the functional --

A. That is, and I've reviewed this in the past. Yes.

Q. Okay. Now, was this performed by the

physical therapists that were working with him, or is it a separate organization?

A. I don't know the answer to that.

Q. Well, you see NovaCare rehabilitation at the top there?

A. I do.

Q. Is that an organization that you work with in your work?

A. In workers' compensation, sure, I've worked with NovaCare before but in workers' compensation typically the employer chooses not only the surgeon but also the rehabilitation. So the answer is I don't know. I don't know at this time.

Q. All right. But you've seen many of these FCE reports, I take it --

A. Sure.

Q. I take it in your work? I'm going to read the summary on the first page. It says the results of this evaluation indicate that Leslie McDermott demonstrates the material handling capabilities to meet the physical demand requirements of a hopper-chief engineer based upon the job description provided by the employer.

Mr. McDermott demonstrates the abilities to function within the heavy physical demand category

according to the U.S. Department of Labor on a full-time basis for an eight hour workday.

Now, based on your experience with these types of reports is this based on an objective physical test given to Mr. McDermott?

A. The answer is that he's given a physical test. The results of that test, however, as we alluded to earlier, can be subjective based upon his response to it.

So the test has some objectivity to it, and it is designed to see how the patient tolerates. However, as alluded to earlier, the tolerance is somewhat subjective.

Q. But these are geared to standards issued by the Department of Labor; is that right?

MR. MORGAN: Objection to form.

Q. Take your time.

A. To my knowledge, yes.

Q. And in the paragraph right after that, I'm not going to read the entire thing, but based on your experience with these reports is this the very specific findings of NovaCare as a result of the tests in terms of how much he can lift, how much he can pull, those sorts of things?

A. They provided a report with that information,

yes.

Q. Okay. And that's not an evaluation. That's what he was actually able to do; right?

A. That's what he did during the test.

Q. Okay. And down at the bottom of the page it says physical demand level heavy. Is that a category that we talked about before?

A. Yes, it is.

Q. Now, you received this report?

A. I did.

Q. Which, by the way, was the date of the evaluation was May 15, 2017?

A. Yes. I received it.

Q. Okay. If you could just before we leave this report, if you could go to the second to the last page? I just asked you about the category heavy.

Have you seen this before? You see all these categories, physical demand categories, U.S. Department of Labor? I'm sorry. Next to the last page. Well --

A. Yes.

Q. It looks like this (indicating). I wonder if you have an incomplete copy.

A. No. Here it is.

Q. There we go.

A. I see it. Yes.

Q. This is just for the record GLDD994 at the bottom of the page. You've seen these categories --

A. I have.

Q. In your practice. Okay. So Mr. McDermott was classified as heavy in terms of what he was capable of; right?

A. Yes.

Q. And that standard is exerting 50 pounds to 100 pounds of force occasionally and/or 25 pounds to 50 pounds of force frequently and/or 10 pounds to 20 pounds of force constantly to move objects.

Physical demand requirements are in excess of those for medium work, and that's a U.S. Department of Labor standard; right?

A. That is.

Q. Now, when you received this report, if you go to the next tab, you saw Mr. McDermott about 15 days later on May 31st, 2017. Do you see that report?

A. Yes.

Q. Could you go to the second page under history?

A. Yes.

Q. You say currently with activities of daily living he is pain free. He does have what he

describes as mild discomfort when he squats and kneels but says that I can live with it, in quotes.

That's your record of Mr. McDermott's report to you about his pain at that time; right?

A. That's correct.

Q. Now, if we turn to the next page in your plan, at this point you have reviewed the FCE report; correct?

A. That's correct.

Q. And what decisions did you make based on that report?

A. So I will comment quickly on the FCE report since we've gone over it again here in detail. The U.S. Department of Labor heavy comments almost exclusively on the ability to move force in terms of pounds. It does not comment on other activities.

If we go back to the first page, you will notice in the third paragraph, and I will read from it.

Deficits identified during testing include left knee pain, decreased left knee range of motion with flexion and left hip weakness. Functioning to claimant is limited in his ability to kneel.

So in light of that I did tell Mr. McDermott based on his review of this report and his subjective

reports of no pain with activities of daily living, mild discomfort when he squats and kneels and complaints that he could live with it, in quotes, I did say he could return to work.

Q. Okay. And that was May 31st, 2017; right?

A. That is correct.

Q. And more specifically, what you said in that report, he feels ready to return. Return to work date will be June 12th. Up until June 12th I am clearing him to work with heavy work restrictions. After June 12th no restrictions.

So that was your determination of his fitness to return to duty; correct?

A. Yes.

Q. Okay. And if you go to the next page, there is a separate form here. We're going to see several of these in your papers. It says Work Capabilities Report. Is this a report that you filled out?

A. Yes.

Q. And this is dated May 31st, '17?

A. Yes.

Q. Same date as you saw him?

A. Yes.

Q. And here you say return to work full duty on June 12th, and then you have heavy work checked off?

A. That's right.

Q. It says 100 pounds max lift, carry, push, pull 50 pounds frequently. Walks, stands frequently.

A. Correct.

Q. Is this a form that you're required to fill out for workers' compensation?

A. Yes.

Q. Is it submitted to a government body?

A. I do not know the answer to that.

Q. Okay. Is it submitted to the employer, do you know?

A. It is.

Q. And if you could go to tab eight?

A. Okay.

Q. You may never have seen this before, but I just want to ask you if you happen to know about it.

A. Tab eight was the work comp. So tab nine?

Q. I'm sorry. You're right. Okay. Tab nine? I will represent to you that Mr. McDermott in June of 2017 after you cleared him to go back to work --

A. Okay.

Q. Underwent a physical for a job he applied for with a company called Weeks Marine in the dredging business.

A. Uh-huh.

Q. And I wondered if you've ever seen this before?

A. I've never seen that before.

Q. Okay. If you look at the last page in this tab, the finding by the physician was physically capable to meet the demands of the position offered with no limitations.

The position that he was applying for was something called an oiler.

A. Okay.

Q. Works on vessels. And that wouldn't be surprising to you that this physician reached that conclusion, would it?

A. No. I'm looking at the date of the exam was 6-22-17. I cleared him for full activity as of 6-12 so that would not be surprising to me.

Q. Okay. If you could go to tab ten? This is your report of a visit on August 9th, 2017.

A. Yes.

Q. Is that right?

A. Yes.

Q. Okay. And this is after he had completed one of the stints back in the dredging industry; correct?

A. Yes. He had been working for almost two

months at that point.

Q. Okay. And what he reported to you in the history, third from the last line, his only complaint is some pain when he kneels on the knee. No other complaints of pain, mechanical symptoms or swelling. He's able to walk and lift without any issue. Discomfort when he kneels directly onto the anterior aspect of the knee.

What does that mean, the anterior aspect of the knee?

A. The front part of the knee.

Q. So on the kneecap?

A. Yes.

Q. Okay. Now, if we could go down to plan, you say with regard to the knee itself he's doing very well. He does have some kneeling pain, which I reassured him can be common after an arthroscopy.

So from that do I take it that anyone who undergoes an arthroscopy for any ailment problem with the knee might have kneeling pain?

A. That's true.

Q. You mentioned the possibility to him of using a knee pad in that visit; right?

A. Yes, correct.

Q. Did he ever tell you if he ever did that?

A. Not to my knowledge.

Q. He reported according to this he does feel, though, he can do his work without restrictions. He tells me he can live with the anterior pain he has when kneeling, and that it is better than it was before surgery.

That last part puzzles me from the standpoint of this. Did he tell you that he had pain performing his job before you first saw him in November 2016?

MR. MORGAN: Objection to form.

A. No, but that's not what that says.

Q. Okay. Maybe I'm misunderstanding it.

A. It says that his pain that he has now is better than it was before surgery. So that can be 15 minutes before surgery or a day before surgery. He had pain as a result of an injury for which we did surgery.

In addition to the surgery that he had, in the third line, we gave him an injection back in February, the first injection that he had.

So this is a gentleman who's enjoying relief from his pain from a number of modalities, the first of which is the surgery that was performed, the second of which is the non-operative treatment of his arthritic condition, the cortisone injection, the

antiinflammatory medication administered in February.

Six months later still enjoying reasonable relief with the exception of some knee pain when kneeling which as we stated can be present in any patient who undergoes an arthroscopy.

Q. Okay. Did he tell you anything about this particular job that he had just finished actually on August 3rd, just days before he saw you? Did he tell you what activities he was doing, what he had to do?

A. I can't recall, and there's nothing documented.

MR. DeGIULIO: Go off the record a minute.

VIDEOGRAPHER: We're going off the record. The time is 5:58 p.m.

(Pause.)

VIDEOGRAPHER: Back on the record. We're going back on the record. The time is 5:59 p.m.

BY MR. DeGIULIO:

Q. Dr. Frank, thanks for your continued patience here. Could you go to tab 11 --

A. Sure.

Q. In this collection of documents? Am I correct this is your report from a visit on

October 25th, 2017?

A. Correct.

Q. Now, do you recall is that the first time you had seen him since August, the visit we just looked at?

A. I believe so.

Q. Did he tell you anything about an additional job he had taken in the dredging industry between August and the date of this visit?

A. Nothing other than he was working. To my knowledge there were two jobs. If there was another one, I'm not aware.

Q. Okay. Let me see if this might refresh your recollection. This particular job he was working on a beach.

A. Okay.

Q. Not on a ship or a barge. Did he ever mention that to you?

A. I have no documentation of that, not that I can recall.

Q. Okay. So if we just go down to the bottom of the page, we're now nearly, we're approaching a year out --

A. Yes.

Q. From the date that he claims he was injured.

Under plan, the third from the last line, he may continue to work in a full duty capacity.

He made that determination on October 25th, 2017; right?

A. That's right.

Q. That reinforced your prior opinion?

A. That's correct.

Q. Quickly turn to the next page. It's another Work Capabilities Report. This one's dated October 25th, 2017. This simply confirms what I just read from your report.

A. That is correct.

Q. That he can return to full duty, no restrictions; correct?

A. That is correct.

Q. And then tab 13 is a letter that you wrote to Mr. Morgan dated November 15, 2017. Do you recall what the origin of this letter was? I mean did you know Mr. Morgan before this?

A. No. This was a request for a summary of care rendered so --

Q. Did Mr. Morgan call you sometime prior to that date and ask you to do this?

A. No. The normal course of things is a letter request.

Q. Did you happen to see such a letter in your file?

A. I'm sure I saw it at some point. I don't have it in the file now.

Q. You don't have it in the file now?

A. No.

Q. Okay. I'm just asking because you reviewed your file today before this deposition; right?

A. Yes.

Q. You didn't see it?

A. I did not see the letter.

Q. Okay.

A. Those types of letters usually are not kept as part of the medical record.

Q. Okay. So if we turn to the second page which at the bottom is PLDISC 128, in the second paragraph, we've already talked about this, third sentence.

During the time of his diagnostic arthroscopy we identified some Grade II and III degenerative changes, particularly in the lateral compartment.

Just so the judge and jury understands, it's pretty complicated stuff, that describes changes to the articular cartilage; correct?

A. Correct.

MR. MORGAN: Objection to form.

Q. It does not in any manner refer to the meniscus; correct?

A. Correct.

Q. Do you consider the surgery that you did on Mr. McDermott successful?

A. Yes.

Q. It achieved what it was designed to achieve; correct?

A. It achieved what it was designed to achieve within the limitations of what I could do given his knee.

Q. Fair enough.

A. Yes.

Q. Okay. If you can turn to tab 14, this is a particular tab. I think it's a combination of documents. The first document is a Work Capabilities Report.

Well, before I ask you a question, Mr. McDermott came back to you in May of this year; right?

A. That is correct.

Q. And you did not ask him to come back. He asked to come back; isn't that right?

A. That's correct.

Q. Okay. What's the term PRN mean?

A. As needed.

Q. Okay. So if I see in these reports that further treatment contains that abbreviation which must be Latin --

A. Yes.

Q. That means that he can come back if he needs to come back?

A. That's correct.

Q. And he can seek treatment if he thinks he needs it?

A. That's correct.

Q. So he came back to you, and we're going to look at your actual visit report in a minute but --

A. Okay.

Q. What you ended up doing on 5-16-18, May 16th of this year, is again reconfirming that he could work full duty without restrictions; right?

A. That is correct.

Q. Now, when he came back in May, did he, and you can obviously look at your notes which follow this, did he tell you anything about having again worked in the dredging industry since the last time he had seen you in October?

A. I don't know that he specifically addressed

that. I believe it was assumed that was continuing work in the same industry.

Q. Okay. At no time did he tell you he couldn't do that; right?

A. No. He was doing so with discomfort.

Q. Okay.

A. Specifically, when he squats and climbs steps.

Q. Okay. Now, if you could look at -- we're still in tab 14.

A. Yes.

Q. It's the third page of the document. At the bottom of the page it says 2291.

A. Okay.

Q. Do you see that?

A. Yes.

Q. Again, going to the section on plan, do you see that?

A. Yes.

Q. It says his company doctor has recommended a repeat MRI. Do you know what that refers to, the company doctor?

A. I assume this is somebody he's seeing. I don't know exactly, but I assume somebody he's seeing at the request of his employer.

Q. Did you ever speak with any doctor who claimed to be representing the employer?

A. No.

Q. Okay. Now, continuing on then, you refer to this request for an MRI. You say while I think that is reasonable, I do believe that most of his symptoms are coming from osteoarthritis.

A. Yes.

Q. And is that something that shows up on an MRI?

A. Yes.

Q. Did you recommend that he have the MRI?

A. I did.

Q. Just at the end of the section on plan, you reconfirmed once again that he could continue to work full duty without restrictions?

A. That's correct.

Q. Now, he got a cortisone injection this time; right?

A. He did.

Q. And each time that he got one during this period of time he reported to you that it helped a lot; right?

A. He reported that it helped.

Q. Let's go to tab 15, this report which is

dated May 30th, 2018, this year.

A. Yes.

Q. Had you received the results of the MRI that you ordered prior to this visit?

A. Not prior. I reviewed them during the course of the visit.

Q. But you had the results at this time?

A. Yes.

Q. Okay. And what did you see?

A. We saw some degenerative changes. We saw post surgical changes of the medial meniscus, not unexpected given his clinical course.

There was also some post surgical changes at the junction of the posterior horn and body lateral meniscus, again not unexpected given the surgery that he had 18 months prior.

There was no definitive evidence of knee tear and other than arthritic change I felt that these represented post surgical changes, and I related those findings to Mr. McDermott.

Q. That terminology, post surgical changes, to a layman like me sort of throws me off.

A. Okay.

Q. Is what you're really trying to convey is that what you see in the knee is something that you

would expect from the procedure you had done back in December of 2016?

A. That, in addition to the arthritic condition for which we've also been treating him, yes. You know, the purpose of the MRI for me as a clinician is to determine is this a patient who could benefit potentially from further surgery or not from further surgery.

In my opinion I did not think he needed any further surgery based on those findings.

Q. We have one final document.

A. Yes.

Q. Well, in this collection.

A. Okay.

Q. And this is another Work Capabilities Report. Did you prepare this?

A. Yes.

Q. And that was May 30th of this year?

A. That's correct.

Q. And, again, you reconfirmed that he could work in a full duty capacity without any restrictions; correct?

A. Yes.

Q. Have you been shown a report done by a Dr. Robert Mannherz?

A. Not to my recollection.

Q. Have you ever heard of Dr. Mannherz?

A. No.

MR. DeGIULIO: Okay. As a result of that answer, I have no further questions.

EXAMINATION

BY MR. MORGAN:

Q. While Mr. DeGiulio was asking you questions, I found some other slides. Some of them seem to be duplicates of what we already looked at, but if you would look at those, Dr. Frank, you may find something that would assist us in explaining where the tear was that we couldn't find in the earlier slide of the photograph you took during the arthroscopic surgery.

Is there anything in there that would assist you in explaining the surgery to the court and jury?

A. There is just some additional pictures of the medial meniscus tear toward the bottom here.

Q. Okay. So we're looking at the Medial Meniscus. We're looking at page 66, which if Mr. DeGiulio has no objection, I will just put that in the package of Exhibit No. 1 which is the file papers.

MR. DeGIULIO: No problem.

A. These are just some additional pictures

indicating instability. That's an instrument or a probe there, this flap of tissue --

Q. Here you go.

A. Is displaced. There's a probe there. This is a displaced fragment of meniscus, and again we've looked at the post surgical images.

Q. Yes, sir.

A. After resection so that just indicates the tear further.

Q. Thank you.

A. Okay.

Q. Now, I wanted to cover a couple points that Mr. DeGiulio covered in his cross-examination. One of the questions that he asked you was whether there was a way to objectively determine when a meniscus actually tore.

And by objective, when you use the term in this forensic area of medicine, what do you mean by that?

A. Objective is something that's not subject to any opinion or input that could be subject to question. So, for instance, objective, if you use an extreme example, an objective example in this case would be if Mr. McDermott had an MRI on the deck of the ship, went out and twisted it and that showed no

meniscal tear.

Q. Right.

A. Went out and twisted his knee and went right back into the MRI and had a meniscus tear. To me, that would represent objective unequivocal evidence that between point A and B --

Q. Right.

A. Or between point A and C with event B in the middle.

Q. Right. Okay.

A. So.

Q. You have a photograph of no tear before he goes on the deck. You have a photograph of a tear afterwards?

A. So I would say in almost no situation in medicine do we have that sort of data.

Q. Right.

A. In medicine we always start with a complaint and a history.

Q. Right.

A. So, and we deduce probability of cause based upon temporal relationships of a patient's subjective complaint and history, combine that with objective findings, physical exam findings, radiographic findings, and come up with an opinion.

So there's no absolute -- there are few absolute objective measures in medicine.

Q. Right. When you use this word temporal, do you mean over time?

A. Over time, unrelated.

Q. Okay. So if we use a phraseology, which believe it or not appears frequently in jury instructions, common sense, we know from your testimony that when you have a torn menisci, as did Mr. McDermott, that you have what you would call dysfunctional or somewhat jagged portions of the meniscus in the knee; is that accurate?

A. Yes.

Q. And I believe your testimony has been because they're abnormal they change the, for lack of a better expression, what do you call it when the knee, when it is not as --

A. Kinematics.

Q. Kinematics. Meaning what?

A. Normal function of the knee throughout a range of motion.

Q. All right. So like if I had a chunk of heel tore out of my shoe and tried to walk --

A. Right.

Q. Then my gait would be changed?

A. Reasonable analogy. Yes.

Q. And what you're saying is if you have a piece of cartilage that's jagged or somewhat frayed, then you're going to have a change in gait?

A. A change. It will become symptomatic. That's why meniscus tears are symptomatic.

Q. All right. So if we use common sense and say here we have a 54-year-old gentleman that's engaged in working in the maritime industry day in and day out. He's walking on steel decks. He's pulling on hoses, on occasion has to hook up a hose or disconnect a hose, which means he has to kneel or squat.

And he's never gone to the doctor. He's never complained of any pain to anyone in his life that we know of, and he certainly hasn't stopped working, and then he has this episode that I don't need to repeat but related to you.

He's now in pain. You do an MRI and see the tears in the lateral meniscus and in the medial meniscus.

Does that assist you in establishing whether more likely than not the moment of the tear is connected to the history that he gave you?

MR. DeGIULIO: Objection to form.

MR. MORGAN: Why?

MR. DeGIULIO: It's mischaracterizing what the doctor's already testified to.

MR. MORGAN: Okay. So I always run the risk when these nice smart lawyers make objections. I mean it's sustained.

BY MR. MORGAN:

Q. So I'm going to ask you, Doctor, in your words can you tell us whether you have an opinion as to whether Mr. McDermott sustained the tears to his lateral meniscus and medial meniscus based on the history he gave to you and the objective findings you saw on the MRI and explain your answer?

A. I mean based upon the information that I was given, and to use your term, common sense reasoning, I would say it is my opinion within a reasonable degree of medical certainty that the injury to the knee was caused by the event reported on this ship.

Q. Okay. Secondly, Mr. DeGiulio went through tab after tab of documentation where you released Mr. McDermott to go back to full duty based upon the treatment that you had given to him and his reports to you of how he was doing, and here's the question that arises out of that information.

Given the instance of his returning to you for treatment and his need for steroidal injections

because of pain, does the mere fact that you released him to full duty change the internal, whatever you want to call it, disease process, injury process of the knee. It's still there. Isn't it?

A. He has a chronic progressive disease in his knee that at this point we are managing. All right. And testimony to the management is he has been able to return to work.

The duration to which he will be able to continue that type of work is unknown at this point in time.

Q. Okay. And it would be irresponsible and callous for an orthopedic surgeon such as yourself to dictate to a person whether they can or cannot return to heavy labor if they choose to do so, would it not? That's not something you do?

A. That's correct. His desire to return to work is his desire and, you know, he is managing this disease in his knee and making an effort to make a living.

Q. Has he been a compliant patient that did what you told him to do?

A. In my opinion, yes.

Q. Has he gone through the work strengthening and work hardening so far as you read in the records

cooperatively and with the proper amount of effort?

A. With the information that I have, yes.

Q. The other thing was, I think it was in tab six, NovaCare was a record that you all were talking about here with Mr. DeGiulio.

A. Yes.

Q. And the fact he was able to lift, I think they said, 100 pounds in that record; is that right?

A. I'm seeing 80.

Q. Or 80.

A. Pushing up to 92. Lifting up to 80.

Q. Okay. Can you tell if he's able to do that, is that consistent or inconsistent with showing that the large amount of debilitating osteoarthritis that the defense may argue that he has isn't causing him any pain right now when he does what's on that test result?

A. I think based upon this he could do what they said he could do with limitations and again deficits identified, knee pain.

Q. Knee pain. Okay. So just that there's no confusion on the testimony, it seems to me that the osteoarthritis that you found in his knee was in the, those inner menisci that we saw on this diagram here.

I believe you actually drew an arrow to one

of them. What are those called?

A. That's the articular cartilage.

Q. Articular cartilage, and that's where the osteoarthritis exists; is that correct?

A. That's correct. Mostly in the lateral compartment which is the outside compartment.

Q. All right. Now, using your knowledge of medicine, if you remove 50 percent of the medial meniscus and 20 percent of the lateral meniscus, and we look at one of the other depictions, perhaps this one here which is marked as Frank No. 4, can you explain to the jury when you take out these big, portions of the big meniscus and then you have the smaller articulating cartilages in there, is there more pressure on them than there was before you removed the 50 percent of the medial meniscus and the 20 percent of the lateral meniscus?

MR. DeGIULIO: Objection to form. Lack of foundation. He hasn't testified about how much of the medial meniscus he removed. He testified it was 15 percent of the lateral.

And I think what you're pointing to in the diagram are not the correct anatomical parts.

MR. MORGAN: Okay. Well, that's fine. I appreciate it.

Q. If you refer to the opt report that we looked at earlier, can you find where you designated the amount of medial meniscus removed?

A. It's documented as 50 percent.

Q. Fifty percent?

A. Fifty percent. Five-zero.

Q. Thank you. Now, as we look at Exhibit No. 4 and we look at what I'm talking about here, what is this up here (indicating) trying to replicate?

A. Femur.

Q. And what is this (indicating)?

A. The tibia.

Q. The femur's at the top?

A. That's correct.

Q. That would be like a thigh bone?

A. Thigh bone.

Q. And this is like your shin bone?

A. Shin bone.

Q. Okay. And this here (indicating)? What is this blue thing?

A. I imagine that is supposed to depict the meniscus.

Q. And then the top?

A. That's articular cartilage, the blue.

Q. Okay. So perhaps the best way for me to

phrase this question is if you remove 50 percent of the medial meniscus and 20 percent of the lateral meniscus, is it going to facilitate aggravation of preexisting osteoarthritis in the articulating cartilage?

A. What it's going to do is increase the forces seen by the articular cartilage which could therefore lead to acceleration of arthritic change.

Q. All right. So for lack of more scientific terminology, is it bad for Mr. McDermott's knee joint so far as being pain free that he sustained the injury for which you treated him?

A. It was -- the meniscus tear adversely affected his knee.

Q. Okay. And I don't know why I made a note of this, but in tab 13 I made a note here on page two of the November 17th report. No degenerative changes were noted. Do you know what that refers to?

A. I don't know what that note refers to.

Q. Okay. Oh!

A. Is there something on that page that stated that?

Q. Yes. I think in the center, it doesn't say what I just said, but it says the procedure was performed on December 6, '16 during the time of his

diagnostic arthroscopy. We identified some Grade II and III degenerative changes, particularly in the lateral compartment.

I believe what I was referring to is the degenerative changes were not in the medial meniscus and lateral meniscus but were in the articulating cartilage that you showed in the diagram?

A. That's correct. We diagnosed minimal arthritic change in the medial compartment where the larger tear was.

Q. So before those meniscus tore, by those I mean the medial meniscus and the lateral meniscus, is it true you saw no evidence of preexisting degenerative changes that would make them more easily torn than a normal meniscus?

A. There were degenerative changes in the knee which can render those meniscus more prone to tear.

Q. Okay. And were those areas of degenerative changes that you saw in the knee what you would expect in any 54-year-old person?

A. They were age appropriate.

Q. Okay. All right. So would that be all the more reason that as an employer you would not want to subject that person to torsion forces if there was a way to design the work place to alleviate that?

A. I think an abnormal torsion force on the knee in any line of work is not ideal.

Q. Okay.

MR. MORGAN: Thank you very much. Those are all the questions.

MR. DeGIULIO: I have a couple. I promise.

EXAMINATION

BY MR. DeGIULIO:

Q. You treat, I think you said, 200. Actually, you perform surgery on 200 to 250 patients a year for meniscus tears?

A. Yes.

Q. Okay. Based on that experience, your great experience in this area, is it possible for an individual to go a very long time with a meniscus tear without, before seeking treatment?

A. That is possible.

Q. Does that happen often?

A. It happens.

Q. What percentage of the time?

A. I can't say.

Q. Would you agree with me that the tear of a meniscus, that a person can still function normal daily activities without getting it repaired?

A. Yes.

Q. What's the percentage of the population with osteoarthritis in the knee among 54-year-old male?

A. I can't cite a number, but it's greater than 50 percent.

Q. Greater than 75 percent?

A. Probably.

Q. That's all I have. Oh, one more. I did some reading about what I think is a drug or a product called Xarelto. Are you familiar with it?

A. I'm not.

MR. DeGIULIO: Okay.

EXAMINATION

BY MR. MORGAN:

Q. Just to follow up on the last series of questions, Mr. McDermott in doing work, climbing ladders and kneeling, pulling on hoses and working eight to ten hours or more on steel decks is not what you as an orthopedic surgeon would expect a person with the tears he has in his knee would do pain free, would he?

A. I wouldn't expect it.

MR. MORGAN: Thank you very much. I will pass the witness.

MR. DeGIULIO: All done.

MR. MORGAN: Well done. Thank you.

THE WITNESS: Thank you.

VIDEOGRAPHER: This concludes our deposition. We're going off the record. The time is 6:29 p.m.

(Witness excused.)

(Deposition concluded at 6:29 p.m.)

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C E R T I F I C A T E

COMMONWEALTH OF PENNSYLVANIA)
COUNTY OF BEAVER)

I, Mary Secot, a notary public in and for the Commonwealth of Pennsylvania, do hereby certify that the witness, DARREN A. FRANK, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth; that the foregoing deposition was taken at the time and place stated herein; and the said deposition was recorded stenographically by me and then reduced to typewriting under my direction, and constitutes a true record of the testimony given by said witness, all to the best of my skill and ability.

I further certify that I am not a relative or employee of either counsel, and that I am in no way interested, directly or indirectly, in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office this 23rd day of July 2018.

Mary Secot